STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 00 B. WING	08/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALPARAISO CARE AND REHABILITATION CENTER	606 WALL ST VALPARAISO, IN46383

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F0000	This visit was for the Investigation of Complaint IN00095374. Complaint IN00095374 substantiated, Federal/state deficiencies related to the allegations are cited at F157, F241, F246, F309, F323, F329, and F441. Survey dates: August 30, and 31, 2011 Facility number: 000083 Provider number: 155166 AIM number: 100289670 Survey team: Sandra Haws, RN- TC Census bed type: SNF/NF: 157 Total: 157 Census payor type: Medicare: 25 Medicaid: 120 Other: 12 Total: 157 Sample: 4 Supplemental sample: 38 These deficiencies also reflect State findings cited in accordance with 410 IAC	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post survey desk review on or after September 30, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	16.2 Quality review completed on September 7, 2011 by Bev Faulkner, RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to ensure the physician was	F0157	**F157**	09/30/2011

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	notified of a critically low blood pressure for 1 of 4 residents reviewed for physician notification in a sample of 4. Resident # B Findings include: Resident # B's record was reviewed on 8/30/11 at 9:10 a.m. The resident's record indicated diagnoses of, but not limited to; Obesity, anemia, dementia, atrial fibrillation, congestive heart failure, weakness, history of cerebral vascular accident, impaired renal function, neuropathy, and mitral and aortic valve stenosis. The resident's record indicated she was admitted to the facility on 6/6/11. A nurses note, dated 7/3/11, indicated the resident's blood pressure was documented 132/70 and her pulse was documented at 74. Nurses note, dated 7/5/11, indicated the resident's blood pressure was documented 122/70, her pulse was documented as 72. The resident's Prothrombin Time Report, dated 7/22/11, indicated "Protime 70.0" (a test to check how thin your blood is) normal reading (9.1- 12.5). The physician's order indicated to hold the Warfarin for 3 days and give vitamin K 10 mg p.o. (by mouth) every 8 hours, times 2		**Notification of Changes** It is the practice of this provider to immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action as the alleged deficient practice was in the past and no longer resides at the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · **Residents with change in condition have the potential to be affected by the alleged deficient practice.** · **Licensed nurses notifies the**	

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	days and to repeat the protime on 7/25/11. Nurses note on 7/23/11 at 4 a.m., indicated "97.1 (temperature), 50 (pulse), 24 (respirations), 75/50 (blood pressure) (normal 120/70), Coumadin (Warfarin) (a blood thinner) on hold. No bleeding noted, no black tarry stools noted...." The note failed to indicate the resident's critical blood pressure of 75/50 and a low pulse of 50 was called to the physician. The record further lacked documentation to indicate the resident's blood pressure and heart rate was being monitored. During an interview with the Director of Nursing on 8/31/11 at 11:30 a.m., regarding the resident's critical blood pressure of 75/50 and the lack of documentation to indicate the physician was notified, she indicated the nurse who documented the critically low blood pressure should have called the doctor immediately. This Federal tag relates to Complaint # IN00095374 3.1-5(a)(2)		**physician for change in resident condition. The resident is assessed and monitored until the condition stabilizes.** **· A change of resident condition is reviewed by the interdisciplinary team utilizing the 24 Hour Report Sheets and Physician Telephone Orders, Monday through Friday. The nurse-on-call is notified of resident change of status on the weekends/holidays. The nurse managers ensure the physician is notified and appropriate interventions are initiated, as needed.** **· Licensed nurses will be educated to the facility Change of Condition Policy and Procedure, Physician Telephone Orders and the 24 Hour Report Sheets by the Director of Nursing Services or designee by 9/30/11.** **· Noncompliance with facility policy and procedure will result in employee education and/or disciplinary action up to and including termination.** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** **· The charge nurse completes the 24 Hour Report on their designated shift and notes any change of resident status. The Physician Telephone Orders form is utilized for physician orders or**	

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			changes in resident status that require a change in the resident's plan of care. Notification of family and physician is recorded on this form. **· The Interdisciplinary team will review the 24 Hour Report and Physician Telephone Order form for physician and family notification Monday – Friday (excluding holidays) at the clinical meeting. The interdisciplinary team determines if any further interventions or changes to the plan of care is necessary. The Unit Manager or designee will ensure implementation and compliance.** **· The Nurse Manager on call will be notified of acute resident change of status during non-business hours. The Nurse Manager on call will notify the Director of Nursing Services and/or the Executive Director as needed.** **· The Director of Nursing Services/designee will monitor for clinical and change of condition compliance.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** **· The Physician Telephone Orders and the 24 Hour Report sheets are audited by the Unit Managers and/or designee to**	

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			ensure resident change of condition is reported to the physician, physician orders are followed through timely and care plans are updated. **The Unit Manager will complete a "24 Hour Condition Report " CQI tool. It will be utilized daily x 4** **· weeks, weekly x 8 weeks, monthly thereafter for 3 months to monitor family and physician notification compliance. The audits are reviewed by the DNS/CQI committee and action plans are developed to improve performance, which will include education, skills validations, performance improvement, and/or disciplinary action.**	
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure a resident was treated with respect and dignity related to a staff member (CNA #5) failing to honor a resident's request for fresh water for 1 of 1 resident's reviewed for respect and dignity in a sample of 4. (Resident # TT) Findings include: During an interview with alert and	F0241	**F241 DIGNITY AND RESPECT OF INDIVIDUALITY** The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**	09/30/2011

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	oriented Resident # TT on 8/31/11 at 12:05 p.m., she indicated the pitcher of water that was sitting on her bedside table was 2 days old. She further indicated staff do not always bring fresh water daily. During the interview with Resident # TT, CNA # 5 came into the resident's room to deliver a lunch tray. CNA # 5 was made aware the resident was requesting some fresh water. CNA # 5 replied "This isn't my resident or my hall, you'll have to find the person that works this hall." CNA # 5 then turned and walked out of the resident's room. During an interview with CNA # 5 on 8/31/11 at 12:30 p.m., regarding not honoring Resident # TT's request for fresh water, she became very angry and indicated harshly someone else was passing water. During an interview with the Director of Nursing on 8/31/11 at 1:00 p.m., regarding residents having fresh water, she indicated fresh water is to be passed every shift to those residents able to have water and the water should be accessible to them. This Federal tag relates to Complaint # IN00095374 3.1-3(t)		· There is no corrective action as the alleged deficient practice was in the past. Residents who are able to have fresh water are provided fresh water every shift. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be effected by the alleged deficient practice. All residents who are able to have fresh water are provided it every shift and as requested. · C.N.A. #5 received inservicing and disciplinary action. · All staff will be inserviced on Resident Rights by the SDC/designee before 9/30/11. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Unit Managers monitor resident care by making rounds on their units daily which include the passing of fresh water. Concerns are addressed with the nursing aide, as needed. · Rounds are completed each shift by the charge nurse daily and by department heads Monday - Friday to monitor	

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			resident care. Concerns are addressed with the aides charge nurse utilizing an inservice and/or disciplinary action. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · Nurses will document their rounds on the "Resident Care Rounds" daily. The DNS will review the checklist daily M-F. · Department heads will document on the "Customer Care Rounds" sheets daily. The Guest Relations Coordinator/designee will review the round sheets weekly and it will be ongoing. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures will result in disciplinary action.	
F0246 SS=E	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on interviews, record review and observations, the facility failed to ensure residents in the facility had fresh water or had the water accessible to them for 34 of the 85 residents observed who are able to drink water in the facility. (Resident's # F, # G, # H, # I, #J, #K, #L, #M, #N, #O, #P, #Q, #R, #S,#T,#U, #V,	F0246	**F246 REASONABLE ACCOMODATION OF NEEDS/PREFERENCES** A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents	09/30/2011

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	#W, #X,#Y,#Z, #A, #ZZ, #FF, #GG, #HH, #II, #JJ ,#KK, #LL, #MM, #NN, #RR , and # TT.) Findings include : During a tour of the facility on 8/30/11 at 8:00 a.m., accompanied by the Staff Development Coordinator # 6 and LPN # 7, in an interview with Staff Development Coordinator # 6 at the start of the tour, she indicated the following resident's were able to drink thin water, and none of the following residents were on any type of fluid restriction. The following was observed during a tour of the resident rooms on both the east and west halls: 1. Resident # F's room was observed without any water in the resident's room or on the resident's bedside table. 2. Resident # G's room was observed without any water in the resident's room or on the resident's bedside table. 3. Resident # H's room was observed without any water in the resident's room or on the resident's bedside table. 4. Resident # I's room was observed without any water in the resident's room or on the resident's bedside table.		would be endangered. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** There is no corrective action as the alleged deficient practice was in the past. Residents who are able to have · fresh water are provided fresh water every shift and as requested. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be effected by the alleged deficient practice. Residents who are able to have fresh water are provided fresh water every shift. · All staff will be inserviced on Hydration and Accommodation of Needs by the SDC/designee before 9-30-11 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Unit Managers monitor	

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	5. Resident # J's room was observed without any water in the resident's room or on the resident's bedside table. 6. Resident # K's room was observed without any water in the resident's room or on the resident's bedside table. 7. Resident # L's room was observed without any water in the resident's room or on the resident's bedside table. 8. Resident # M's room was observed without any water in the resident's room or on the resident's bedside table. 9. Resident # N's room was observed without any water in the resident's room or on the resident's bedside table. 10. Resident # O's room was observed without any water in the resident's room or on the resident's bedside table. 11. Resident # P's room was observed without any water in the resident's room or on the resident's bedside table. 12. Resident # Q's room was observed without any water in the resident's room or on the resident's bedside table. 13. Resident # R's room was observed to have a pitcher of water on a bedside table		resident care by making rounds on their units daily. Concerns are addressed with the nursing aide, as needed. · Rounds are completed each shift by the charge nurse and by department heads Monday - Friday to monitor resident care. Concerns are addressed with the aides charge nurse utilizing an inservice and/or disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Nurses will document their rounds on the “Resident Care Rounds” daily. The DNS will review the checklist daily M-F. · Department heads will document on the “Customer Care Rounds” sheets daily. The Guest Relations Coordinator/designee will review the round sheets weekly ongoing. · Data will be submitted to the CQI Committee for review and follow up. Actions plans will be developed if thresholds are not obtained. · Noncompliance with facility procedures will result in disciplinary action.	

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	that was across the room out of the resident's reach. During an interview with the Staff Development Coordinator # 6 during the tour about Resident # R, she indicated the resident falls frequently and needs assistance. 14. Resident # S's room was observed without any water in the resident's room or on the resident's bedside table. 15. Resident # T's room was observed without any water in the resident's room or on the resident's bedside table. 16. Resident # U's room was observed without any water in the resident's room or on the resident's bedside table. 17. Resident # V's room was observed without any water in the resident's room or on the resident's bedside table. 18. Resident # W's room was observed without any water in the resident's room or on the resident's bedside table. 19. Resident # X's room was observed to have the resident's water across the room, out of the resident's reach. 20. Resident # Y's room was observed without any water in the resident's room or on the resident's bedside table.			

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	21. Resident # Z's room was observed without any water in the resident's room or on the resident's bedside table. 22. Resident # A's room was observed without any water in the resident's room or on the resident's bedside table. 23. Resident # ZZ's room was observed to have a pitcher of water across the room, out of the resident's reach. 24. Resident # FF's room was observed without any water in the resident's room or on the resident's bedside table. 25. Resident # GG's room was observed without any water in the resident's room or on the resident's bedside table. 26. Resident # HH's room was observed without any water in the resident's room or on the resident's bedside table. 27. Resident # II's room was observed without any water in the resident's room or on the resident's bedside table. 28. Resident # JJ's room was observed without any water in the resident's room or on the resident's bedside table. During an interview with the Staff Development Coordinator # 6 during the tour about			

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	Resident # JJ, she indicated the resident falls frequently and needs assistance. 29. Resident # KK's room was observed having water across the room out of the resident's reach. 30. Resident # LL's room was observed without any water in the resident's room or on the resident's bedside table. 31. Resident # MM's room was observed to have a pitcher of water on a bedside table that was across the room out of the resident's reach. 32. Resident # NN's room was observed without any water in the resident's room or on the resident's bedside table. 33. Resident # RR's room was observed without any water in the resident's room or on the resident's bedside table. During an interview with LPN # 7 on 8/30/11 at 11:15 a.m., regarding the residents still not having any water, she indicated the water is usually passed every shift and there should have been water in the resident's rooms by now. She indicated the night shift will usually pick up the pitchers and deliver fresh water at that time. LPN # 7 was made aware of			

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	how many residents either didn't have any water or it was not in their reach on both east and west units, she indicated they should have had water this morning. On 8/31/11 at 11:45 a.m., the above mentioned residents still remained without fresh water being delivered to their rooms. During an interview with Resident # ZZ on 8/30/11 at 2:10 p.m., regarding having fresh water available, he indicated they do not always pass the water when they are supposed to. Resident # ZZ pointed across the room at a pitcher of water and indicated it had been there since yesterday. During an interview with alert and oriented Resident # TT on 8/31/11 at 12:05 p.m., she indicated the pitcher of water that was sitting on her bedside table was 2 days old. She further indicated staff do not always bring fresh water daily. During the interview with Resident # TT, CNA # 5 came into the resident's room to deliver a lunch tray. CNA # 5 was made aware the resident was requesting some fresh water. CNA # 5 replied "This isn't my resident or my hall, you'll have to find the person that works this hall." CNA # 5 then turned and walked out of the resident's room. During an interview with CNA # 5 on			

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	155166	A. BUILDING 00 B. WING	08/31/2011

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	8/31/11 at 12:30 p.m., regarding not honoring Resident # TT's request for fresh water, she became very angry and indicated harshly that someone else was passing water. During an interview with the Director of Nursing on 8/31/11 at 1:00 p.m., regarding residents having fresh water, she indicated fresh water is to be passed every shift to those residents able to have water and the water should be accessible to them. The facility's policy titled "Hydration Management" revised 6/11 was reviewed on 8/31/11 at 1:20 p.m. The policy indicated " ...Fresh water will be passed to all residents, unless medically contraindicated, on each shift. 10. Additional fluids will be offered at various times throughout each shift i.e. medication pass, activities, and resident request...." This Federal tag relates to Complaint # IN00095374 3.1-3(v)(1)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident's blood pressure was properly monitored prior to the administration of 2 blood pressure medications with a blood pressure recorded to be critically low just a few hours prior to administering the 2 blood pressure medications for 1 of 4 residents reviewed with blood pressure medications in a sample of 4. Resident #B Findings include: Resident # B's record was reviewed on 8/30/11 at 9: 10 a.m. The resident's record indicated diagnoses of, but not limited to; Obesity, anemia, dementia, atrial fibrillation, congestive heart failure, weakness, history of cerebral vascular accident, impaired renal function, neuropathy, and mitral and aortic valve stenosis. The resident's record indicated she was admitted to the facility on 6/6/11.	F0309	**F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action for resident #B since the alleged deficiency was in the past and no longer resides at the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be affected by the alleged deficient practice. · Nurses will be educated on	09/30/2011

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	A nurses note, dated 7/3/11, indicated the resident's blood pressure was documented as 132/70 and her pulse was documented at 74. Nurses note, dated 7/5/11, indicated the resident's blood pressure was documented as 122/70, her pulse was documented as 72. Nurses note on 7/23/11 at 4 a.m., indicated "97.1 (temperature), 50 (pulse), 24 (respirations), 75/50 (blood pressure) (normal 120/70), Coumadin (Warfarin) on hold. No bleeding noted, no black tarry stools noted...." The record further lacked documentation to indicate the resident's blood pressure and heart rate was being monitored the rest of the night. Nurse note, dated 7/23/11 10:30 a.m., indicated " 106/50 (blood pressure) 54 (pulse)...." The resident's MAR (Medication Administration Record) indicated the resident received her blood pressure medication on 7/23/11 and 7/24/11 at 9:00 a.m., of Atenolol 25 mg along with Vasotec 20 mg. On 7/24/11 at 5:00 p.m., the MAR indicated the resident received her 5:00 p.m. dose of Vasotec 20 mg for blood pressure. The MAR, or the resident's clinical record lacked documentation to indicate the resident's blood pressure or pulse was checked prior		assessment and interventions by the SDC/designee by 9/30/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Unit Manager/designee will audit the 24-hour reports daily in clinical meeting (Mon-Fri) for change in resident condition. The IDT Team will review any resident with a change of condition for appropriate intervention and documentation. Nursing Manager on call will audit the 24-hours report on Saturday for residents with a change of condition. · The IDT Team will review any resident with a change of condition for appropriate intervention and documentation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · A "24 Hour Condition Report" CQI tool will be utilized weekly x 4, then monthly thereafter for 6 months by the Unit Manager/designee. · Data will be submitted to the CQI Committee for review and follow up. If the thresholds are not met an action plan will be	

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	to or after administering any of the blood pressure medications. The resident's plan of care, dated 6/13/11, indicated "Problem: Ineffective tissue perfusion related to dx (diagnosis)hypertension...Approach...Observe for and document:...variations in B/P (blood pressure)..." This Federal tag relates to Complaint # IN00095374 3.1-37(a)		developed. · Noncompliance with facility procedures will result in disciplinary action.	
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interviews and record review, the facility failed to ensure a resident was kept free from falls and injury and subsequently ended up in the emergency room in critical condition for 1 of 4 residents reviewed with falls in a sample	F0323	**F323 FREE OF ACCIDENTS/HAZARDS/ SUPERVISION/DEVICES** The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision	09/30/2011

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	of 4. Resident # B Findings include: Resident # B's record was reviewed on 8/30/11 at 9: 10 a.m. The resident's record indicated diagnoses of, but not limited to; Obesity, anemia, dementia, atrial fibrillation, congestive heart failure, weakness, history of cerebral vascular accident, impaired renal function, neuropathy, and mitral and aortic valve stenosis. The resident's record indicated she was admitted to the facility on 6/6/11. The resident's record indicated the resident preferred to sleep in a recliner verses a bed. During an interview with the Director of Nursing on 8/31/11 at 9:00 a.m., she indicated the resident slept in a recliner at home and preferred not to sleep in the bed and requested the bed to be removed from her room. A form titled "Fall Risk Assessment," dated 6/6/11, indicated the resident was at risk for experiencing a fall. The form indicated she was experiencing symptoms of acute illness or exacerbation of chronic illness, was incontinent of urine or bowel, was on diuretics and a benzodiazepine, and has an impaired gait /balance. A Physical Therapy Progress report, dated		and assistance devices to prevent accidents **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · There is no corrective action for resident #B since the alleged deficiency was in the past and no longer resides at the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · The Unit Manager/designee will review the Fall Risk Assessment for all residents and updated as needed. · The SDC/designee will complete Inservice for staff on Fall Prevention Interventions by 9/30/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Unit Managers monitor resident care by making rounds	

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	6/13/11 through 6/19/11 indicated "... Fall risk...Reason for continuation: Has continued deficits in transfers and ambulation safety." The form indicated "Muscle weakness." A Physical Therapy Progress report dated 6/20/11 through 6/26/11 indicated "... Fall risk...Reason for continuation: Has continued deficits in transfers and ambulation safety." The form indicated "Muscle weakness." Review of a form titled "Fall Circumstance Report," dated 6/26/11 at 6:10 p.m., indicated "...Res (resident) was in recliner and tried to scoot out and plopped on the floor by mistake. Res has no injuries...." The form indicated the resident did not have a history of orthostatic hypotension (low blood pressure moving from sitting to standing position.) The resident's plan of care, dated 6/13/11, indicated "Problem: Fall risk related to SOB (shortness of breath) H/O (history of) falls...The approaches indicated " Encourage and remind resident to use call light, Fall risk assessment, Observe for fall risk contributors such as medications, hypotension, pain unsteady gait. Provide assistance for transfers, bed mobility, Refer to therapy for screening...." The		on their units to ensure fall interventions are in place. Concerns are addressed with the nursing aide, as needed. Rounds are completed each shift by the charge nurse, by department heads Monday - Friday to monitor resident care. Concerns are addressed with the aides charge nurse utilizing an inservice and/or disciplinary action. · The Director of Nursing Services is responsible to monitor for facility compliance. Root Cause Analysis will be conducted to determine possible cause of fall. · Charge nurses/nursing assistants are responsible to ensure residents receive the necessary fall prevention measures that they require. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** **· Observations will be documented on the "Resident Care Rounds" CQI tools weekly x 4, then monthly thereafter.** · The DNS/designee will completed the "Fall Management" CQI tool weekly x 4, then monthly thereafter. · Data will be submitted to the CQI Committee for review and follow up. Actions plans will be developed for thresholds that	

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	plan of care failed to indicate it had been updated after the fall from her chair on 6/26/11. A care plan, dated 6/10/11, indicated "Problem- Resident has short term memory loss...." During an interview with the Director of Nursing on 8/31/11 at 10:15 a.m., regarding the care plan not being updated to help prevent the resident from falling from her chair again, she indicated a safety intervention for the chair should have been added since the resident attempted to get out of it. A Fall Circumstance Report, dated 7/17/11, indicated " ...Res attempted to transfer self into shower chair, change in Xanax (antianxiety medication), Lexapro (antidepressant) and Librium (used for anxiety)...floor damp d/t (due to) shower other res given prior... Re-educate staff to not turn back on res while in shower room. Cont (continue) to provide gentle reminders to res to please wait for assist to transfers...." The form indicated the resident experienced an abrasion to her left knee 5 cm (centimeters) by 3 cm. During an interview with the Director of Nursing on 8/31/11 at 10:30 a.m., regarding the resident falling on 7/17/11,		are not met. · Noncompliance with facility procedures will result in education and/or disciplinary action.	

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	she indicated the CNA was attempting to give Resident #B a shower. While in the shower room with the floor wet, the CNA turned her back and the resident had gotten up from her wheelchair and fell causing an abrasion to her knee. The DON indicated she updated the care plan for staff not to turn their back on the resident. Nurses note on 7/23/11 at 4 a.m., indicated "97.1 (temperature), 50 (pulse), 24 (respirations), 75/50 (blood pressure) (normal 120/70), Coumadin (Warfarin) on hold. No bleeding noted, no black tarry stools noted...." The record further lacked documentation to indicate the resident's blood pressure and heart rate was being monitored the rest of the night. Nurse note, dated 7/23/11 10:30 a.m., indicated " 106/50 (blood pressure) 54 (pulse)...." The resident's MAR (Medication Administration Record) indicated the resident received her blood pressure medication on 7/23/11 and 7/24/11 at 9:00 a.m., of Atenolol 25 mg along with Vasotec 20 mg. On 7/24/11 at 5:00 p.m., the MAR indicated the resident received her 5:00 p.m. dose of Vasotec 20 mg for blood pressure. The MAR, or the resident's clinical record lacked documentation to indicate the resident's blood pressure or pulse was checked prior to or after administering any of the blood			

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	pressure medications. Nurse note, dated 7/24/11 at 2:00 p.m., indicated '...Res has increased anxiety. Res keeps complaining of falling. Res encouraged not to transfer self in order not to fall...." Nurse note, dated 7/24/11 at 5 p.m., indicated "Res found lying on (R) (right) side on floor in room laceration to (R) forearm and above (L) (left) eyebrow noted. Res c/o (complains of) chest pain. Sent to (hospital) ER (emergency room) for eval and treatment MD (medical doctor) and family notified." A statement written by LPN # 3, dated 7/24/11, indicated "Aide called me into resident's room. Resident lying on her right side on the floor with head near the air conditioner unit. Resident's right arm and face was covered with blood. Small amount of blood on floor. Laceration to the (R) forearm and above the left eyebrow noted. Res complained of chest pain...." A statement written by LPN # 4, dated 7/24/11, indicated "Res called out for help, Res found on floor, while another aide was bringing in the tray. Res was lying on (R) side. Res had blood on arm			

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	and forehead due to cuts. Res was fully dressed call-light was within reach but not on, no-slip socks present...nurse sent Res to ER 911." A Fall Circumstance Report form. dated 7/24/11 5:00 p.m.. indicated the fall was unwitnessed "...vital signs BP 121/60...Pulse 83...Resident stated she was in a basement, wasn't able to re-call what happened...Reeducation about call light...." During an interview with the resident's family member on 8/30/11 at 12:20 p.m.. regarding the resident's fall on 7/24/11. The family indicated the resident's entire left hip was black and blue along with the top of her head and behind her ears after the fall. The family member indicated the resident expired a few days after being sent to the hospital. During an interview with the Director of Nursing on 8/31/11 at 11:30 a.m., regarding the resident's critical protime, critical blood pressure while taking blood pressure medications, lack of documentation indicating any blood pressure monitoring was being done, a low pulse, along with the resident being on Xanax with a diagnosis of weakness with recent falls, she indicated the nurses failed to look at the entire picture related			

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	to fall prevention. This Federal tag relates to Complaint # IN00095374 3.1-45(2)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interviews and record review,	F0329	**F329 DRUG REGIMEN IS FREE**	09/30/2011

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	the facility failed to ensure a resident was monitored while on blood pressure medications related to the resident having a critically low blood pressure and not being monitored prior to giving two blood pressure medications 5 hours later for 1 of 4 residents reviewed with blood pressure medications in a sample of 4. Resident #B Findings include: Resident # B's record was reviewed on 8/30/11 at 9:10 a.m. The resident's record indicated diagnoses of, but not limited to; Obesity, anemia, dementia, atrial fibrillation, congestive heart failure, weakness, history of cerebral vascular accident, impaired renal function, neuropathy, and mitral and aortic valve stenosis. The resident's record indicated she was admitted to the facility on 6/6/11. The resident's July 2011 medications include but are not limited to; Atenolol 25 mg (blood pressure) daily at 9:00 a.m. and Vasotec 20 mg (blood pressure) two times daily at 9:00 a.m. and again at 5:00 p.m. A nurses note, dated 7/3/11, indicated the resident's blood pressure was documented as 132/70 and her pulse was documented at 74.		**FROM UNNECESSARY DRUGS** Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences, which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** There is no corrective action for resident #B since the alleged deficiency was in the past and no longer resides at the facility.	

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Nurses note, dated 7/5/11, indicated the resident's blood pressure was documented as 122/70, her pulse was documented as 72.

Nurse's note on 7/23/11 at 4 a.m., indicated "97.1 (temperature), 50 (pulse), 24 (respirations), 75/50 (blood pressure) (normal 120/70)." The record lacked documentation to indicate the resident's blood pressure and heart rate was being monitored the rest of the night.

Nurse note, dated 7/23/11 at 10:30 a.m., indicated " 106/50 (blood pressure) 54 (pulse)...." The resident's MAR (Medication Administration Record) indicated the resident received her blood pressure medication on 7/23/11 and 7/24/11 at 9:00 a.m. of Atenolol 25 mg along with Vasotec 20 mg. On 7/24/11 at 5:00 p.m., the MAR indicated the resident received her 5 :00 p.m. dose of Vasotec 20 mg for blood pressure. The MAR, or the resident's clinical record lacked documentation to indicate the resident's blood pressure or pulse was checked prior to administering any of the blood pressure medications.

A care plan, dated 6/13/11, indicated "Ineffective tissue perfusion related to DX hypertension...Observe for and

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken

· Residents residing in the facility have the potential to be affected by the alleged deficient practice.
· Nurses will be inserviced on the use of unnecessary drugs including assessment and documentation by the SDC/designee by 9/30/11.
· Noncompliance with facility policy and procedure will result in employee
education and/or disciplinary action up to and including termination.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur

· The Interdisciplinary team will review the 24 Hour Report and Physician Telephone Order form Monday – Friday (excluding holidays) at the
clinical meeting. The Unit Manager or designee will ensure implementation and compliance.
· The charge nurse will notify physicians of abnormal blood pressures.

· **Nurses will be inserviced on the use of unnecessary drugs**

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	155166	A. BUILDING 00 B. WING	08/31/2011

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VALPARAISO CARE AND REHABILITATION CENTER	606 WALL ST VALPARAISO, IN46383

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	document:...variations in B/P...Notify MD." A care plan, dated 6/13/11, indicated "Fall risk related to SOB (shortness of breath), weakness, H/O (history of) falls...Approach...Observe for fall risk contributors such as medications, hypotension, pain, unsteady gait, provide assistance with transfers...." During an interview with the Director of Nursing on 8/31/11 at 11:30 a.m., regarding the resident's critical blood pressure while taking blood pressure medications, the lack of documentation indicating any blood pressure monitoring was being done, a low pulse, with a diagnosis of weakness and recent falls, she indicated the nurses failed to look at the residents entire picture, the resident's blood pressure should have been monitored. According to "Nursing Spectrum Drug handbook, 2010 related to the following medications the resident was taking, indicated the following: Vasotec 20 mg two times a day. Drug reference; "... PO (by mouth) onset 1 hr (hour), peak 4-6 hours, duration 24 hours. Patient monitoring : assess for rapid blood pressure drop leading to cardiovascular		**including assessment and documentation by the SDC/designee by 9/30/11.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** **· The DNS/designee will audit the medication administration records and document on the "MAR CQI" Audit tool three times a week x 4 weeks, then once weekly x 4 weeks, then monthly ongoing for compliance.** **· The audits are provided to the Executive Director for review. Noncompliance is discussed with the CQI committee and action plans are developed to improve performance, which will include education, skills validations, performance improvement, and/or disciplinary action.** **· The CQI committee will review data obtained. If threshold is not achieved, an action plan will be developed.**	

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	collapse, especially when giving with diuretics...instruct pt (patient) to move slowly when sitting up or standing to avoid dizziness or light-headedness from sudden blood pressure decrease..." Resident #B was taking Lasix 40 mg two times daily, a diuretic. Atenolol 25 mg daily: "... Onset 1 hr, peaks in 2 hours, duration 24 hrs, pt monitoring; tell pt that drug may cause a temporary blood pressure decrease if he stands or sits up suddenly. Instruct him to rise slowly and carefully...." This Federal tag relates to Complaint # IN00095374 3.1-48(a)(3)			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observations and interviews, the facility failed to ensure the resident's rooms were free from potential infectious material related to soiled gloves on the resident's bedside table and floor	F0441	**F441 INFECTION CONTROL, PREVENT SPREAD, LINENS** The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable	09/30/2011

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	(Resident's # XX and # ZZ) , urinals containing urine sitting on the bedside tables for Residents # A, # ZZ and # BB, a resident's commode with 5 inches of urine in it (Resident # YY) and soiled linen on the floor for Residents # XX and # CC. This deficient practice has the potential to affect all residents residing in the facility. Findings include: During a tour of the facility on 8/30/11 at 8:00 a.m., accompanied by the Staff Development Coordinator # 6, the following observations were made: 1. Resident # XX's room was observed to have 3 soiled gloves on the floor. The gloves were turned inside out as if they had been removed. Resident # XX's room was observed to have a pile of soiled bed linen on the floor. The Staff Development Coordinator # 6 summoned staff to pick the linen up off of the floor. 2. Resident # ZZ's bedside table was observed to have a urinal containing 2 inches of urine in it and soiled gloves next to the urinal on the table. 3. Resident # A's room was observed to have a urinal on his bedside table one fourth full of urine.		environment and to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Observations were made of all rooms to ensure urinals and commodes were emptied, linen from floor and gloves were removed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be effected by the alleged deficient practice. · Observations were made of all rooms to ensure urinals and commodes were emptied, linen from floor and gloves were removed. · All staff will be educated on infection control as to the appropriate cleaning of urinals, bedside commodes and transferring of soiled linen by the SDC/designee by 9/30/11. **What measures will be put into place or what systemic changes you will make to**	

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	4. Resident # BB's bedside table was observed to have a urinal three quarters full of urine. 5. Resident # YY's commode was observed to have 5 inches of urine in the commode bucket. During an interview with Staff Development Coordinator # 6 during the tour, she indicated staff are to keep all commodes and urinals empty and clean. She further indicated a small amount of soap should be placed in the commode after cleaning to aid in preventing odors. On 8/31/11 at 11:45 a.m., the resident's commode was observed again containing 2 inches of urine. 6. Resident # CC's room was observed to have a pile of soiled bed linen on the resident's floor. During an interview with the Director of Nursing on 8/31/11 at 1:40 p.m., regarding the above issues, she indicated all urinals and commodes are to be emptied immediately and washed by staff. She indicated there should not be any linen on the floor or urine being left in commodes or urinals. She further indicated urinals should not be on the resident's bedside tables. This Federal tag relates to Complaint #		**ensure that the deficient practice does not recur** · The SDC/designee will make infection control rounds and document on the "Infection Control Review" form at least 3 times weekly for 4 weeks, then once weekly there after. · Rounds are completed routinely each shift by the charge nurse, by Customer Care Reps Monday - Friday to monitor resident care. Concerns are addressed with the aides charge nurse. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Observations from rounds will be documented on the "Infection Control Review" CQI tool weekly x 4, then monthly thereafter by the DNS/designee. · Data will be submitted to the CQI Committee for review and follow up. Action plans will be developed if the threshold is not obtained. · Noncompliance with facility procedures will result in disciplinary action.	

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	IN00095374 3.1-18(b)(1)			